

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

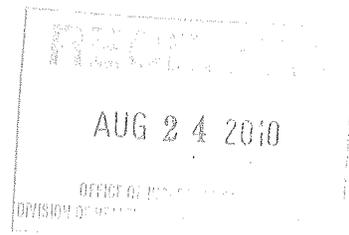
PRINTED: 08/12/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185360	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/29/2010
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NAME OF PROVIDER OR SUPPLIER GALLATIN HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 499 CENTER STREET WARSAW, KY 41095
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
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F 323	<p>Continued From page 20</p> <p>by: Based on record review, interview and observation it was determined the facility failed to ensure the physical environment for one (1) of the eighteen (18) sampled residents was free of accident hazards (Resident #1). The facility failed to obtain and read the manufactures recommendation for the bed and mattress provided by Hospice and failed to educate the nursing staff in those recommendations. The facility failed to identify hazards and risk factors for Resident #1, consequently the resident rolled out of bed and sustained a skin tear to the elbow and required an x-ray of the shoulder. The facility failed to identify the cause of the fall and failed to assess and monitor interventions implemented to determine effectiveness. In addition, the facility failed to identify all risk factors in determination of the use of side rails.</p> <p>The findings include:</p> <p>Review of the facility's policy on Mattress Pressure Redistribution dated 03/01/08 indicated an attempt to prevent pressure ulcers and to assist with the healing of existing ulcers; all residents will have a pressure redistribution mattress on their bed. "An M.D. order is obtained for the specific type of pressure redistribution mattress.... the above listed mattress are the currently stocked mattresses only and does not consider mattresses supplied by outside agency (e.g., Hospice, VA, private agencies, personal mattresses, etc.)."</p> <p>Record review for Resident #1 revealed an admission date of 03/17/09 and diagnoses of Adult Failure to Thrive, Joint Stiffness, Chronic Pain, Dementia and Anxiety. Review of the</p>	F 323 F 323/N 219	<ol style="list-style-type: none"> 1. Resident #1 sustained a skin tear to the elbow on 7/4/10 as a result of rolling off the mattress. She was assessed for injury. Treatment was provided to skin tear and an X-Ray of her shoulder was obtained which was subsequently found to be negative. The facility replaced the Hospice mattress with an AccuMax mattress provided by the facility with proper manufacturers' guidelines in place on 7/28/10. 2. An audit of all mattresses for residents receiving Hospice care was conducted on 7/28/10. All Hospice mattresses were replaced with facility owned mattresses on 7/28/10. 3. The facility will provide all mattresses to residents receiving Hospice care. Staff Development/designee initiated an in-service, which was conducted on 7/28/10 to review manufacturers' recommendations for all nursing employees related to facility owned mattresses. Completed by 8/21/10. The review of the manufacturers guidelines will be added to the orientation checklist for the nursing department on new hires. 4. The QA nurse/designee will conduct an audit weekly for one month and monthly thereafter ensure compliance with manufacturers recommendations. The findings will be presented to the Quality Assurance committee monthly. 	Completion date: 8/21/10
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F 323	<p>Continued From page 21</p> <p>Annual MDS dated 02/19/10 indicated the resident required assistance of one staff member to change position in bed and two staff members for a stand-pivot-sit transfer. The resident was admitted to Hospice care on 04/07/09 and the alternating low air loss mattress was provided for the resident by Hospice on 02/11/10. The Side Rail Intermittent Review form dated 11/28/09 indicated the reason for the assessment was Quarterly review and concluded the resident did not require the use of side rails. The annual review dated 02/15/10 indicated the resident had no changes in side rail needs since last assessment and continued to not require the use of side rails even though the specialty mattress had been added to the treatment plan on 02/11/10, four (4) days prior. The side rail assessment failed to consider how slick the surface of the mattress was and that a sheet was not utilized as recommended by the manufacturer. On 07/04/10 the nurses' notes indicated the resident slid out of bed onto the floor sustaining a skin tear to the elbow and complaints of pain in the bilateral shoulders with some abnormal bone structure. An order for an x-ray was obtained and it was subsequently negative.</p> <p>Observations on 07/27/10 at 11:25am and 2:22pm, on 07/28/10 at 9:00am, 10:00am, 2:30pm and 4:05pm, revealed the resident lying in bed on alternating low air loss mattress with no sheet on the bed and no side rails in use. Observations on 07/29/10 at 7:40am revealed Resident #1 lying in a low PVC frame bed with a Mason 6500 mattress covered with a sheet.</p> <p>Interview with LPN #8 on 07/28/10 at 3:05pm, revealed she was responsible for the care of Resident #1 and was in-serviced by the Hospice</p>	F 323		

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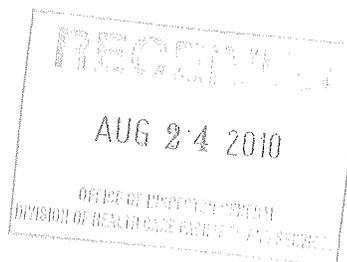
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F 323	<p>Continued From page 22</p> <p>delivery person on how to keep the bed inflated, make the wheels move and control the settings. She indicated the mattress did not require the use of a sheet and was not aware of the manufacturer's manual or recommendations.</p> <p>Interview with the Hospice RN on 07/28/10 at 3:20pm revealed she had not read the manufacturer's instruction booklet regarding the low air loss mattress; however, it did not have a requirement for the use of a sheet. In addition, she had been in-serviced on the mattress a couple of times.</p> <p>Interview with the KMA (Kentucky Medication Assistant) on 07/28/10 at 2:50pm revealed Resident #1 utilized a low air loss mattress. The staff do not place a sheet on the mattress and she did not read the manufacturer's instruction for the use of the mattresses.</p> <p>Interview with SRNA #3 on 07/28/10 at 2:55pm revealed the nurses told her not to place a sheet on the mattress because of the type of mattress it was. The nurse would tell the CRNAs if a mattress requires the use of a sheet or other protection.</p> <p>Interview with LPN #5 on 07/28/10 AT 3:15pm revealed she was in-serviced on setting up the bed and mattress; however, the manufacturer's manual was not presented to them and she had not read it.</p> <p>Interview with the ADON (Assistant Director of Nursing) on 07/28/10 at 3:32pm revealed when the resident slid out of bed the sheets were on top of her. She knows that with any air mattress the toppers are slick and this mattress had a slick</p>	F 323		
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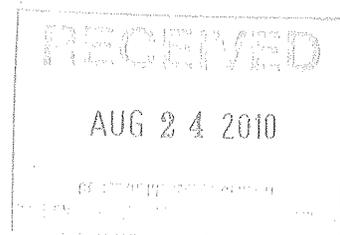
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F 323	<p>Continued From page 23</p> <p>surface. She did not read the manufacturer's manual and did not read them after the fall.</p> <p>Interview with the DON (Director of Nursing) on 07/28/10 at 3:47pm revealed most manufacturers do not recommend the use of a sheet on low air loss mattresses. She would have to get the manufacturer's manual to read it.</p> <p>Review of the manufacturer's user manual, provided by the manufacturer, regarding the Altus Deluxe low air loss mattress and alternating pressure pump system, indicated the staff should read the manual throughout before attempting to use the product. Installation step 2 indicated to cover with a cotton sheet to avoid direct skin contact and reduce friction. Operation Instructions - under general indications stated please cover the mattress with a cotton sheet to avoid direct skin contact for the patient's comfort. Although the manufacturer's recommendations did not mention the use of side rails the instructions utilized a picture of a bed with full siderails.</p> <p>Interview with the DON on 07/28/10 at 3:40pm revealed the facility had no evidence of any in-services completed for the use of the low air loss mattress to the nursing staff and did not have the manufacturer's manual on hand.</p> <p>Review of the plan of care for pressure, falls and cognition dated 02/16/10, developed 5 days after the initiation of the mattress as an intervention, revealed the facility did not address the risk factors i.e.: slick surface of the low air loss mattress, lack of side rail usage and the requirement to use a cotton sheet.</p>	F 323		
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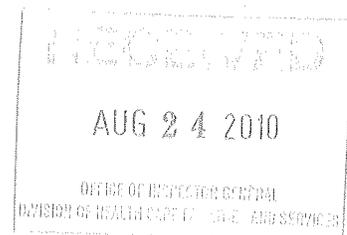
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F 323	Continued From page 24 Interview with the ADON on 07/28/10 at 3:32pm revealed an investigation was completed; however, she could not produce any evidence and stated the cause of the fall would be in the nurses' notes. Review of the nurses' notes dated 07/04/10 indicated the event and the results of the fall but not the cause. Review of the fall care plan revealed post fall on 07/04/10 and interventions in place were effective and would continue the same. On 07/07/10 a wedge cushion was put in place to the resident's right side of the back when in bed. An assessment was not completed to determine whether or not the resident was appropriate for restraint initiation, reduction, less restrictive measures or elimination of the wedge. Interview with the Administrator on 07/29/10 at 5:15pm revealed when DME (Durable Medical Equipment) is brought into the facility, it is the responsibility of the DME provider to educate the staff on the use of the equipment. This information is passed on to other shifts. There is no evidence of staff education on this bed and mattress. The manufacturer's manual was not in the facility at time of receiving the bed for Resident #1.	F 323		
F 371 SS=D	483.35(I) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371		



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F 371	Continued From page 25 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to prepare and distribute food under sanitary conditions as evidenced by dust on the stove hood, and hot dogs that were thawing on a towel outside the activity director's office. The findings include: 1. Review of the facility's policy titled Safety and Sanitation #A:6.14 revealed Employees should clean hoods regularly to prevent accumulation of dirt and grease and #A:6.1 revealed Employees should maintain equipment, work surfaces, walls and floors in sanitary condition through daily, and ongoing procedures of established cleaning schedules. Observation of the kitchen's stove hood on 07/27/10 at 9:00am revealed presence of dust on the overhead hood vent of the stove. Interview on 07/27/10 at 9:00am with the Dietary Supervisor revealed she posts a cleaning schedule every two weeks and monitors the log on an ongoing basis. She stated she had posted a cleaning schedule on 06/18/10 and should have put a new one up prior to going on vacation on 06/28/10. A new cleaning schedule did not get posted until she returned on 07/14/10. Documentation indicated that the stove hood had not been cleaned since 07/07/10 and prior to that was 06/06/10. The Dietary Manager stated that it is important to ensure hoods are clean so no dust	F 371	F 371/ N 283 1. No residents were affected by the deficient practice. 2. No other residents were found to be affected by the deficient practice of improper thawing or dust on the stove hood. 3. The certified dietary manager conducted an in service on the importance of the stove hood and filter cleaning on 8/3/10 with the dietary department. The cleaning schedule of the hood and filters will be increased to weekly. The dietitian will conduct a weekly audit of the hood to ensure it remains sanitary. The dietitian educated the activity department on proper thawing of foods on 8/3/10. They were educated on placing frozen items in the refrigerator on the bottom shelf to fully defrost. 4. The dietitian / designee will conduct a weekly audit of the filters and stove hood for dust for one month and once a month thereafter to ensure compliance of sanitary conditions. The Administrator/designee will monitor food related activities on a weekly basis for three months to ensure proper thawing techniques are being used and once a month thereafter. The findings will be presented to the Quality Assurance committee monthly. Completion date: 8/3/10	
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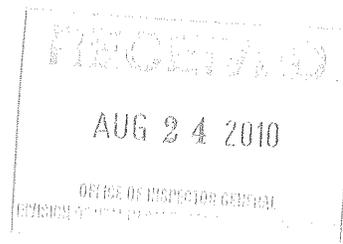
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F 371	Continued From page 26 or dirt gets in residents' food. She stated the dust could possibly make the residents sick. 2. Observation of the facility on 07/29/10 at 8:00am, near the dining room revealed seven packages of frozen hot dogs on a table, thawing on a towel. Interview on 07/29/10 at 10:00am with the Dietary Manager revealed the hot dogs were not part of the dietary department. She stated that the hot dogs were brought in by the Activities Manager for an event later in the day. The Dietary Manager stated she was not aware of the plan to bring in frozen hot dogs to the facility. Interview on 07/29/10 at 5:30pm with the Activities Director revealed she did not know the proper thawing protocol for meat for consumption of residents. The Activities Director stated she had not been trained or in-serviced on the proper way to thaw foods.	F 371		
F 372 SS=D	483.35(l)(3) DISPOSE GARBAGE & REFUSE PROPERLY The facility must dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to properly dispose of garbage and refuse properly. The dumpster had loose sausage links, pastries, orange slices, jelly containers and paper products on the top of the closed lid of the dumpster with flies swarming the food items and the trash dumpster.	F 372 F 372/ N 284	1. No residents were affected by the deficient practice. 2. No other residents were found to be affected by the deficient practice. 3. An in-service was conducted on 8/2/10 by both the dietary department and housekeeping department on the proper disposal of trash in the dumpsters. The supervisors demonstrated the proper way to dispose of trash in the dumpster and cleaning up spills. 4. The dietitian/designee will inspect the proper disposal of trash on a weekly basis for one month and monthly thereafter to ensure	



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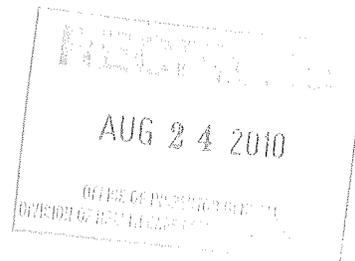
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F 372	Continued From page 27 The findings include: Observations of the exterior of the facility on 07/28/10 at 4:00pm and at 5:05pm revealed a dumpster with loose sausage links, pastries, orange slices, jelly container and paper products on the top of the closed lid of the trash dumpster with flies swarming the food items and dumpster. Interview with the director of maintenance on 07/28/10 at 5:10pm revealed he was unaware of the food items and the paper products on top of the dumpster. He stated he believed maybe a bag had broken, or the trash had been picked up but he could not explain how the trash items were left on top of the dumpster. He reported the food items and the garbage were not to be left out in the open and uncontained for the flies to be on.	F 372	compliance. The findings will be presented to the Quality Assurance committee monthly. Completion date: 8/2/10	
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.	F 425 F425/N306	<ol style="list-style-type: none"> 1. No residents were found to be adversely affected by the deficient practice. The two broken devices were replaced immediately on 07/29/2010 and an in-service was started with all nurses to be completed by 08/21/2010 to ensure all medically related devices are maintained in a manner that would provide safe, sanitary and accurate test results. 2. An audit of all glucometers was completed on 07/29/2010 and no further devices were found to be broken. 3. The Staff Development nurse initiated an in-service with all nurses to be completed by 08/21/2010 to ensure all medically related devices are maintained in a manner that would provide safe, sanitary and accurate test results. 	



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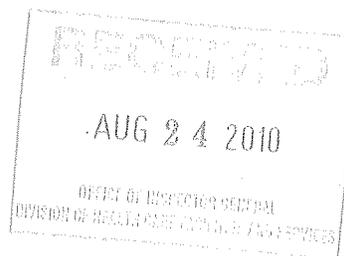
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F 425	<p>Continued From page 28</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain sanitized medically-related devices in a manner that would provide safe and accurate test results for residents receiving medications based on those test results. Two (2) of three (3) blood glucose testing machines on Unit A were found to be broken and taped together.</p> <p>The findings include:</p> <p>Review of the facility policy for sanitizing blood glucose testing devices revealed the devices were to be sanitized after each use.</p> <p>Observation of the blood glucose testing devices on Unit A, on 07/29/10 at 9:35am, revealed two (2) of the devices were broken at the area where the test strips were inserted into the machine and the residents' blood was applied in order to obtain a blood glucose reading. Both machines had been reassembled and taped with clear plastic medical tape. The tape had pulled away in some areas leaving the area around the device insertion site sticky. The tape was cracked and broken leaving a rough surface on the device.</p> <p>Observation of Licensed Practical Nurse (LPN) #9 on 07/29/10 at 10:00am revealed she sanitized the blood glucose device by using a sanitizing wipe on the cracked plastic tape.</p> <p>Interviews with LPNs' #9 and #10 on 07/29/10 at</p>	F 425	<p>The nurses have been instructed to remove any device that is broken from usage immediately. One additional glucometer will be kept in the medication room at all times.</p> <p>4. The Quality Assurance Nurse or designee will conduct a weekly audit of all glucometers weekly for four weeks and monthly thereafter to assure all devices are maintained in a manner that will provide safe, sanitary and accurate test results. The findings will be reported to the Quality Assurance committee monthly.</p> <p>Completion date: 08/21/2010</p>	
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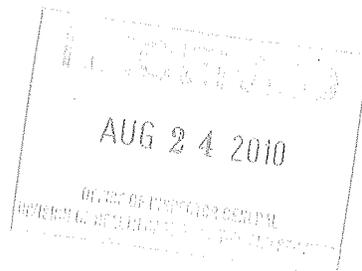
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F 425	Continued From page 29 10:00am, revealed the sanitizing wipes could not clean the device with all the tape cracks and ridges, and that new devices would have to be obtained that could be easily sanitized between resident use.	F 425		
F 431 SS=F	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	F 431 F431/N313	<ol style="list-style-type: none"> No residents were found to be negatively affected by the deficient practice. The open bottle of Normal Saline and Betadine were destroyed as of 07/29/2010. There were two medication carts, including the cart with a broken corner that was replaced on 08/01/2010 with new carts. Additionally, the other four carts were cleaned/disinfected by 07/29/2010. The three pill crushers were cleaned/disinfected as well on 07/29/2010. The Quality Assurance nurse completed an audit on 07/29/2010 to identify any other open biologicals that were out of the recommended window of use or for any that may have expired and no further deficient practice was observed. The Quality Assurance nurse completed an audit on 07/29/2010 of all medication/treatment carts and pill crushers with no further deficient practice observed. The Staff Development nurse initiated an in-service for all nurses and KMA's on 07/29/2010 to be completed by 08/21/2010 to address labeling and expiration of biologicals used in the facility. The in-service also included proper cleaning procedures for the medication carts and pill crushers. A procedure was implemented to assure all medication carts and pill crushers remain sanitary at all times to include nightly cleaning of the carts by the night shift nurses/KMA's in addition to cleaning them as 	



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NAME OF PROVIDER OR SUPPLIER GALLATIN HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 499 CENTER STREET WARSAW, KY 41095
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F 431	Continued From page 30 This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview it was determined the facility failed to label drugs and biologicals in accordance with current professional principles. Bottles of Normal Saline and Betadine were on the medicine cart and had been previously opened with no dates on the bottle. In addition, it was determined the facility failed to maintain the cleanliness of medication equipment and the medication carts. The findings include: Observation of the Medication Room on Unit A on 07/29/10 at 9:35am revealed three (3) of three (3) pill crushers had brown debris in the crevices and around the moving parts of the crusher. Three (3) of three (3) medication carts were soiled inside and outside with brown and white particles and drips of dried substances. The corner of one (1) medication cart was broken off and had metal showing through. Interview with Licensed Practical Nurse (LPN) #10 on 07/29/10 at 10:50am revealed the nurse was to keep the medication cart cleaned during their shift; however, she stated the medication cart and pill crusher she was using for residents' was soiled and had not been cleaned. Interview with LPN #9 on 07/29/10 at 10:00am, revealed the medication cart she was using was not clean on the inside or the outside and the pill crusher had debris around all the edges. She stated the medication carts were to be kept clean	F 431	needed. The nurses/KMA's were in serviced on the new procedure starting on 07/29/2010 and will be completed by 08/21/2010. 4. The Quality Assurance nurse or designee will conduct weekly audits of the medication carts, pill crushers and biologicals weekly for four weeks to assure compliance with sanitary conditions and to assure all biologicals are being used in accordance with labeling and expiration recommendations. The licensed pharmacy staff will audit the medication carts, pill crushers and biologicals monthly thereafter to assure compliance. The findings will be reported to the Quality Assurance committee monthly. Completion date: 08/21/2010	
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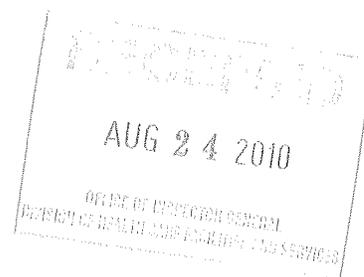
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F 431	Continued From page 31 by each nurse as the cart was used. Observation on 07/29/10 at 10:40am of the 400 hallway medication cart revealed, in the bottom drawer on the right hand side, designated for solutions, were two (2) bottles of Normal Saline and one (1) bottle of Betadine. All three (3) had been previously opened and none had dates on the bottles for the date they were opened. Review of the Medication Care Pharmacy sheet on 07/29/10 at 1:00pm revealed that Normal Saline, Betadine and other solutions that have a 24 hour window for use after opening should be discarded after the 24 hour period. Interview with LPN #3 and LPN #4 on 07/29/10 at 1:10pm revealed, nurses should put the date and time bottles of solutions such as Normal Saline and Betadine are opened so they can be discarded at the end of 24 hours. Both agreed this is considered current professional practice. LPN #3 agreed she had seen the pharmacy sheet listing medications and solutions which had expiration dates of ninety days or less.	F 431		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility;	F 441		



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F 441	Continued From page 32 (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to utilize sanitary techniques for assisting residents during two meal observations. Staff did not protect their hands prior to directly touching residents' food during service. The findings include: Review of the facility policy on Safety and Sanitation revealed all personnel will practice safe	F 441 F 441/ N 144	1. No residents were found to be negatively affected by the deficient practice. 2. No other residents were found to be negatively affected by the deficient practice. 3. The dietitian conducted an in-service on proper handling of ready to eat foods on 8/3/10 and all staff will be in serviced by 8/21/10. Staff will be educated upon orientation and annual competency tests on the proper handling of ready to eat foods. 4. The QA nurse/ designee will monitor five meal services per week on proper handling of food for four weeks and one meal a week thereafter to ensure compliance with sanitary techniques for assisting residents with meals. The findings will be reported to the Quality Assurance committee monthly. Completion date: 8/21/10	
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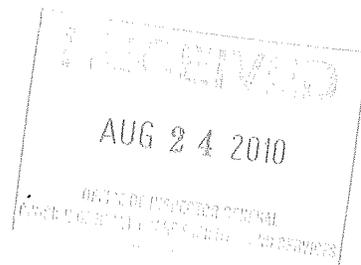
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F 441	<p>Continued From page 33 hygiene food handling technique.</p> <p>Observation of the dining room during a meal, on 07/27/10 at 11:45am, revealed Certified Nursing Assistant (CNA) #3 took bread out of the wrapper with his/her bare hands and placed it on the resident's plate. Continued observation revealed Licensed Practical Nurse (LPN) #3 picked up the resident's bread and sliced the bread in half then laid it back down on the resident's plate.</p> <p>Interview on 07/29/10 at 10:10am with LPN #3 revealed she should not have touched the resident's food with bare hands. The LPN stated she does not normally work in the dining room. When she does help, she sets up trays, makes sure the dietary card is correct for resident and diet, ensures they have the correct assistive devices and helps to butter bread if needed. She related that she was not thinking yesterday and acknowledges she contaminated the resident's food. She stated she has been in-serviced on food safety but does not remember the last time an in-service was done.</p> <p>Interview on 07/29/10 at 10:20am with CNA# 3 revealed she normally works on the floor, not in the dining room. She describes her tray process as taking the tray in, taking lids off containers, helping with cream and sugar and asking residents if they need assistance with buttering bread. CNA #3 stated she normally does not handle food with bare hands and that she usually wears gloves. She stated she remembers cutting the bread with her bare hands but does not know why she touched the food with her bare hands. CNA #3 stated she has attended in-services but does not recall the last in-service on food handling.</p>	F 441		
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F 441	Continued From page 34 Observations of the lunch meal on 07/28/10 at 11:53am revealed LPN #3 set up a meal tray of bean soup and corn bread. The resident was asked if they wanted the cornbread in their soup and the resident replied yes. LPN #3 proceeded to pick up the cornbread and crumbled it with bare hands into the soup. Continued observation at 12:10pm revealed LPN #3 set up a second meal tray for another resident and proceeded to place the cornbread into the soup bowl with bare hands. Interview with the LPN #3 on 07/29/10 at 10:10am revealed her responsibility in the dining room during meal time was to help serve trays and assist with feeding. She explained setting up a tray entailed checking the tray card for accuracy, assist devices if needed, cut up meat, salt and pepper and help butter bread. The LPN continued reporting that she typically does not touch the resident's food; however, she was not thinking and could have contaminated the food. LPN #3 further indicated she had been in-serviced on not touching the resident's food barehanded and indicated she knew better.	F 441		
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